Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-0384-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Work Compensation claims are to be reimbursed 125% of the Mediocre allowable. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 2nd quarter 2014, E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%. Attached is a copy of the CGS Fee Schedule for the E0217, 2nd quarter 2014. Per SUBCHAPTER G. PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE. 134.660. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care. All durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expect cumulative rental)."

Amount in Dispute: $1,424.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual based its payment on the ceiling level for E0217RR, which is $60.44. Multiply this by 1.25 to get $75.77. Divide that amount by 30 days to get a per diem of $2.52. Multiply that by 7 units and the result is $17.64. No additional payment is due. Texas Mutual declined to issue payment… No documentation was provided either by the surgeon or the requestor showing these criteria were met, thus warranting the use of the device. Providing the device without proper showing exceeds the recommendation of ODG's Treatment Guidelines for the Shoulder. For this reason preauthorization is required and was not obtained. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2014	E0127, E0673, E0675	$1,424.28	$57.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

3. 28 Texas Administrative Code §137.100 defines medical treatment guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - 891 - No additional payment after reconsideration
   - 930 – Pre-authorization required, reimbursement denied
   - 762 – Denied in accordance with 134.600 (P) (12). Treatment/service in excess of DWC Treatment guidelines (ODG) per disability management rules.

Issues

1. What is the applicable rule that determines the applicable fee guideline?
2. Was pre-authorization required?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The carrier alleges that HCPCS code E0217 should be paid at a daily rate, for a seven day rental period. According to the *Medicare Pricing, Data Analysis and Coding* contractor, www.dmepdac.com, this code is listed as "Inexpensive and routinely purchased."

   Per the Centers for Medicare/Medicaid Claims Processing Manual, www.cms.hhs.gov, Chapter 20, items in this category may be billed as follows: "30.1 - Inexpensive or Other Routinely Purchased DME (Rev. 1, 10-01-03), For this type of equipment, contractors pay for rentals or lump-sum purchases. However, with the exception of TENS (see 30.1.2), the total payment amount may not exceed the actual charge or the fee schedule amount for purchase." Also found in the Medicare Claims Processing Manual, Chapter 20, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies 130.8 - Installment Payments (Rev. 1, 10-01-03), "Where a beneficiary is purchasing an item through installments, the total price of the equipment item is reported on the first bill. Monthly payments are made (by the DMERC, carrier, FI or RHHI). The monthly amount is equivalent to the rental fee schedule amount and is paid until the fee schedule purchase price or actual charge has been reached, whichever comes first." The daily versus monthly rental is not applicable to this service. Therefore, the carrier's position of daily calculations is not supported.

   For the submitted code (E0217, RR), the carrier included remark code 790 – "This charge was reimbursed in accordance to the Texas Medical Fee Guideline." 28 Texas Administrative Code §134.203 (d) states in pertinent part, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;…" Per the 2013 DMEPOS fee schedule, **https://www.dmepdac.com/dmecsapp/do/feesearch**, the maximum allowable reimbursement will be calculated as follows; the allowable amount $60.44 x 125% = $75.55.

2. The carrier denied the submitted codes E0675 and E0673 as, 762 – "Denied in accordance with 134.600 (P) (12). Treatment/service in excess of DWC Treatment guidelines (ODG) per disability management rules" and 930 – "Pre-authorization required, reimbursement denied." 28 Texas Labor Code §137.100 (a) states in pertinent part, "Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)." Review of the Official Disability Guidelines (ODG) finds;
   a. Compression garments – "Not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy."
   b. Venous thrombosis - In the shoulder, risk is lower than in the knee and depends on: (1) invasiveness of the surgery (uncomplicated shoulder arthroscopy would be low risk but arthroplasty would be higher risk); (2) the postoperative immobilization period; & (3) use of central venous catheters… "It is recommended to treat patients of asymptomatic mild UEDVT

with anticoagulation alone and patients of severe or extensive UEDVT with motorized mechanical devices in conjunction with pharmacological thrombolysis, without delay beyond 10–14 days."

No documentation was found to support disputed services had been prior authorized. The carrier's denial is supported. No additional payment can be recommended.

3. The total recommended payment for the services in dispute is $75.55. This amount less the amount previously paid by the insurance carrier of $17.57 leaves an amount due to the requestor of $57.98. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $57.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $57.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.